

# An Evaluation of the Implementation of Integrated Community Home-Based Care Services in Vhembe District, South Africa

Gandi J Moetlo, Supa Pengpid, Karl Peltzer<sup>1</sup>

Department of Health System Management and Policy, National School of Public Health, University of Limpopo (Medunsa Campus), Pretoria, <sup>1</sup>HIV/AIDS, STI and TB Research Programme (HAST), Human Sciences Research Council, Pretoria and University of the Free State, Bloemfontein, South Africa

*Address for correspondence: Prof. Karl Peltzer; E-mail: kpeltzer@hsr.ac.za*

## ABSTRACT

**Aim:** The aim of the study is to evaluate the implementation of integrated community home-based care (CHBC) services in Vhembe District, Limpopo Province, South Africa.

**Materials and Methods:** In all, 393 caregivers responded to a questionnaire on various aspects of home-based care and service provider characteristics.

**Results:** Results indicate that in most areas of the Community Homes-based Care (CHBC) services, caregivers had confidence including wound dressing, health education, bet bathing, giving prescribed medication, and management of diabetes client, and they had sufficient knowledge received through training. Lower knowledge and confidence was noted for the management of hypertensive and asthmatic clients, and lower knowledge (82%) was indicated for counseling. The most common caregiving services included health education (100%), giving medication (98%), management of hypertension (22%), and counseling (15%). Most caregivers rated the implementation of CHBC in their district as excellent or good (70%). The most common problems and barriers in caregiving included (1) structural problems: none or sometimes not available home-based care kits (54%), lack of resources (32%), lack of transport money (30%), and very low stipend (22%); (2) problems with the supervisor such as “lack of management skills” (40%) and “selfishness” (38%); and (3) problems with clients and community such as “patients not taking prescribed medicines regularly” (45%) and “not welcomed by patients and family members” (35%).

**Conclusion:** Community home-based caregivers are largely able to implement home-based care services but would need more support (training, financial, career structure, and health system) to improve on their services.

**Key words:** Caregiving, Community home-based care, HIV/AIDS, Implementation evaluation, South Africa

## INTRODUCTION

According to the World Health Organization (WHO),<sup>[1]</sup> home-based care refers to the provision of health services by formal and informal caregivers within the home. The aim of home-based care is ultimately to

“promote, restore and maintain a person’s maximum level of comfort, function and health, including care towards a dignified death.”<sup>[2]</sup> The WHO<sup>[1]</sup> foresees home-based care as an integral and integrated aspect of health care. Home-based care is defined as the care that the health consumer (beneficiary) can “access nearest to home, which engages participation by people, responds to the needs of people, encourages traditional community lifestyle and creates responsibilities.”<sup>[2]</sup> In essence, home-based care can be considered as an alternative to traditional institutionalized care, focusing on palliative care in the home. Palliative care refers to the “Active total care of a patient whose disease is not responsive to curative treatment.”<sup>[2]</sup> It should not be viewed, however,

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as “second class care” or “cheap care” for those who are unable to afford institutional or hospital care. Instead it should be seen as a means to effectively treating commonly occurring diseases and illnesses within the home, which do not necessarily require institutionalized care.<sup>[2]</sup> Russell and Schneider<sup>[3]</sup> summarized home-based care and support as “all activities that are based outside conventional health facilities (hospitals, clinics, and health centers) but which have linkages with the formal health and welfare sector and which “addresses any aspect of the continuum of care and support, from the time of infection through to death and impact on survivors.” Home-based care therefore is ultimately any form of care given to the sick within their home.<sup>[1]</sup> However, it should be noted that although the aim is to provide care to the sick within their homes, the patients who are being dealt with by home-based care models predominantly are human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) patients.<sup>[2,4]</sup>

Home-based care models in general adopt a holistic approach to care.<sup>[2]</sup> Physical, social, psychological, emotional, economic, and spiritual factors are all taken into account and considered collaboratively with, and within the community setting.<sup>[5]</sup> Communities need to be integrated into the existing system. Home-based care models are also generally person-centered and comprehensive,<sup>[2]</sup> with the aim to take into account factors such as culture, religion, and value systems, and respect people’s rights to privacy and dignity, which fits in well with its “community-driven” philosophy.<sup>[2]</sup> They are comprehensive and all-encompassing in terms of being preventative, promotive, therapeutic, rehabilitative, and palliative.<sup>[2]</sup> Multisectoral involvement and interdepartmental involvement is highly encouraged. Home-based care models aim to empower communities, thereby promoting autonomy and functional independence.<sup>[2]</sup> Home-based care models also aim to offer basic and essential components of primary health care, adhering to basic principles in health care and development.<sup>[5]</sup> Psychological support and disease acceptance has been reported to be worse for people with AIDS than for patients with other diagnoses,<sup>[6]</sup> and caregivers have similarly reported that providing care for AIDS patients is often more time consuming and stressful than caring for patients with other diagnoses.<sup>[7]</sup> High levels of psychosocial distress including denial, blame of others for the infection, and hopelessness regarding the future are often associated with psychological symptoms.<sup>[6]</sup> The need for HIV/AIDS patients to be loved, accepted, and feel secure is amplified by the fact that many people with AIDS will have experienced rejection as a direct result of their diagnosis. Therefore, HIV/AIDS patients

often experience a sense of multiple losses, which clearly exaggerates their psychological perception of the disease. Experienced losses may include loss of control, loss of dignity, loss of future, loss of family support, and loss of body image and so forth.<sup>[8]</sup> Rejection, isolation, and guilt may be compound with the feeling of being useless, hence their loss of self-esteem too.<sup>[8]</sup>

Campbell and Foulis<sup>[9]</sup> reviewed existing research into home-based care in sub-Saharan Africa and found that multilevel factors undermine carers in performing their role, including lack of knowledge, skills, and support (both at the individual and organisational levels); physical and psychological burnout; the destruction of household economies in the face of the demands of care; and community stigma and rejection.

The aim of the study is to evaluate the implementation of integrated community home-based care services in Vhembe District of the Limpopo Province.

## MATERIALS AND METHODS

### Study design

The research evaluates the implementation of integrated community home-based care programme in Vhembe District of Limpopo Province, South Africa. Vhembe District is a large, mainly rural (76%), district lying in the northern part of Limpopo Province boarding Zimbabwe in the north, Botswana in the west, Kruger National Park, and Mopani District in south east. This District is composed of four local municipalities, i.e. Thulamela, Makhado, Mutale, and Musina, and has a population of 1,281,822. The study focused on all home-based caregivers ( $N = 1874$ ) who are providing home-based care services in all four local municipalities of Vhembe District.

### Sample and procedure

Data were collected at the four Local Municipalities under Vhembe District Municipality, namely: Musina, Mutale, Makhado, and Thulamela. The visits for data collection were done in Makhado in Tshilwavhusiku Health Centre (17 caregivers), in Mutale in Mutale Health Centre (392 caregivers), in Musina (15 caregivers), in Thulamela in William Eadie, in Makwarela, and in Shayandima (257 caregivers). Both the quantitative and qualitative questionnaires were self-administered whereby all 450 respondents were given a questionnaire. Out of all the questionnaires administered, 396 were returned, which makes response rate of 88%. The

study protocol was approved by the ethics committee of the School of Public Health, Medunsa Campus Research Ethic Committee of University of Limpopo, as well as the Research Committee of Department of Health and Social Development, and informed consent was obtained from participants' prior participation.

## Measure

Qualitative data collection included questions on: (1) the challenges and limitations faced by home based caregivers on service delivery, (2) the implementation of CHBC, and (3) the services provided by CHBC programs and the human resources required to carry out these services after course offered. The quantitative questions were composed of four sections, namely: (1) socio-demographic characteristics of the caregivers, (2) perception and satisfaction about training course, and knowledge about home-based care services, (3) services delivered after receiving training, and (4) problems or barriers hindering home-based care services and support needed.

## Data analysis

Descriptive statistics was used with the Statistical Package of Social Sciences (SPSS, version 12), and open-ended questions were content analyzed.

# RESULTS

## Sample characteristics

From the total sample of 396 CHBW's, most were female (96%), with male only being 4%. When examined by age, 4% were between 25 and 29 years, 23% were between 30 and 34 years, and 34% were between 35 and 39 years, with the remaining 39% almost evenly divided among those 40–44 years (14%), 45–49 years (15%), and those greater than 50 years (10%). The majority of the members of CHBC were single (48%), followed by married (40%). About 77% of CHBW's had secondary education as their highest qualification, with 10% possessing tertiary qualifications. Most CHBW's earned a monthly stipend of R500-00 (1 US\$ = 7.5 Rand), followed by R1000-00, with CHBC supervisors earning between R1000-00 and R2500-00.

## Knowledge and confidence

In most areas of CHBC, participants had confidence in the service they were rendering including wound dressing, health education, bed bathing, giving prescribed medication, and management of diabetes clients, and they had sufficient

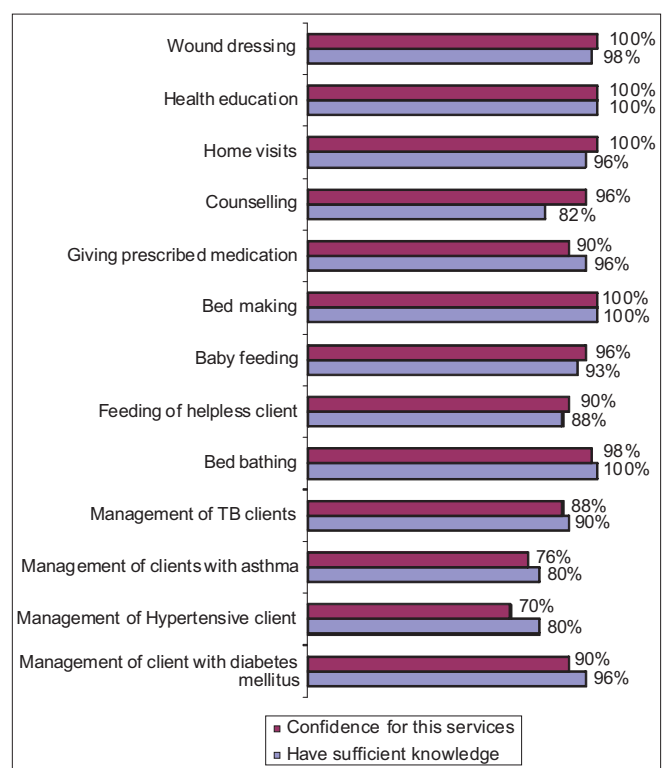
knowledge received through training. In all areas of CHBC, more than 70% of the respondents indicated to have sufficient knowledge and confidence for this service. Lower knowledge and confidence was noted for the management of hypertensive and asthmatic clients, and lower knowledge (82%) was indicated for counseling [Figure 1].

## Training satisfaction and needs

Caregivers felt that training manuals were the most required tool, with 91% for improvement of CHBC, followed by transport arrangements (88%) and contents of training provided (51%) as a required component in the improvement of services. Most (89%) indicated that a refresher training course would be helpful. Communications and venue were components with very little impact in the improvement required for the service. These results indicate that caregivers were mostly interested in learning or getting more information or knowledge about the service they offer.

## Community home-based care services

Figure 2 shows that the top three services rendered by caregivers were health education (100%) and giving medication (98%). About one-fifth of the caregivers provided services for management of hypertension (22%)

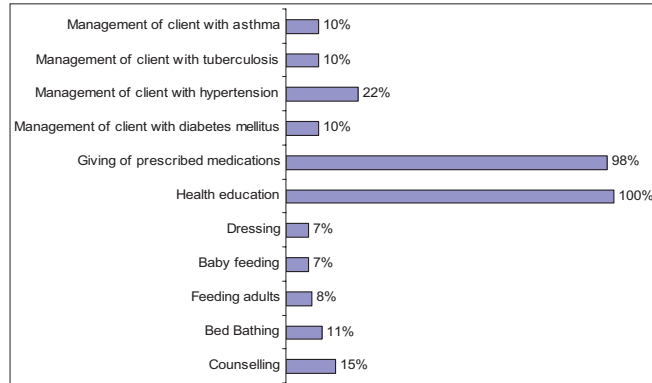


**Figure 1:** Distribution of knowledge and confidence to work after completion of course by caregivers at Vhembe district (N=396)

and counseling (15%). The other categories of services provided were about 10% and less.

Caregivers rated the implementation of community home-based care in their district as excellent (46%), followed by good (24%) and poor (7%). Most clients (78%) who visited

CHBC come directly from home, followed by self-referral clients (14%) and the church (6%). The main role player in CHBC was the priest (45%), followed by politicians. Almost all CHBC open from Monday to Friday and 85% open for 8 h, with 15% less than 8 h; none opened 24 h or from Sunday to Saturday.



**Figure 2:** Percentage distribution of services rendered by the CHBC in Vhembe district (N=396)

### Problems and barriers on rendering CHBC

The most common problems and barriers in caregiving included (1) structural problems: none or sometimes not available home-based care kits (54%), lack of resources (32%), lack of transport money (30%), and very low stipend (22%); (2) problems with the supervisor such as “lack of management skills” (40%) and “selfishness” (38%); and (3) problems with clients and community such as “patients not taking prescribed medicines regularly” (45%) and “not welcomed by patients and family members” (35%) [Table 1].

**Table 1: Percentage of respondents on problems and barriers on rendering community home-based care (n = 396)**

The radius covered by your center	<5 km	5 km	10 km	15 km
	27%	33%	44%	15%
Percentage of home-based care center equipped with home-based care kits	Sometimes	Always	None	
	36%	46%	18%	
Mode of transport for clients to home-based care center	Own transport	Local bus	Taxi	Government vehicle
	0%	20%	80%	0%
The relationship among home-based caregivers	Weak	Fair	Good	Excellent
	1%	4%	51%	44%
The relationship between home-based caregivers and clients	Weak	Fair	Good	Excellent
	0%	0%	52%	48%
Form of support a caregiver gets	None	In-service training	Counseling	Others, specify
	1%	89%	10%	0%
Uniforms for caregivers for identification			20%	
Not welcomed by patients and family members			35%	
No patients care and support from the community			16%	
Caregivers not always welcomed by members of the families			19%	
Patients ignoring caregivers when giving them support visits			9%	
Patients not appreciating services			5%	
Patients not taking prescribed medicines regularly			45%	
Patients refusing services			7%	
Lack of funds			10%	
Lack of resources			32%	
Lack of knowledge about home-based care			6%	
Interference from community			5%	
Supervisor withholding updated information from caregivers			25%	
Lack of transport money			30%	
Stipends is very low			22%	
Stigmatize by very sick patients			12%	
Lack of management skills from supervisor			40%	
Selfishness by supervisor			38%	
Interference by community leaders			8%	
No problems or barriers experience			80%	



## DISCUSSION

In this study, the components of CHBC were documented to determine how community home-based caregivers perceived their knowledge about services that they were rendering, to investigate if the home-based care course offered was equipping caregivers to render community home-based care services as expected, to evaluate if the implementation of community home-based care services in Vhembe District based on the National Health Guidelines, and to identify problems and barriers hindering the delivery of home-based care services in Vhembe District, understanding and identifying the key limitations and challenges. These key components were categorized into structural organization, interventions, and other factors.

### Management skills

There was pervasive limitation throughout the research, with emphasis on the lack of management skills by supervisors, the lack of sharing of updated information, and the extremely selfishness. There was also some mention of other technical expertise that was necessary for improved programme delivery and expansion, which were also important factors to consider. The shortage of healthcare professionals working alongside CHBC programs stems from the root problem of a shortage of healthcare professionals across the board in the health infrastructure. Therefore, this challenge is of greater magnitude, not unique to CHBC programs and cannot be properly addressed within the scope of this study. However, it is worth mentioning as it is a challenge which impacts on CHBC, especially when discussing strong critical ill patients. From the responses of the organizations, the caregivers were the key human resource structure of the CHBC program. There was a lack of clear understanding on duties and roles of the supervisor and caregivers. The issue of stipends for caregivers differed among participants but most felt that the lack of insufficient incentives was one of the main challenges to CHBC. A large incentive raises the issues of quality care and the purpose of a CHBC.<sup>[4]</sup> As local volunteers add an advantage as they would understand the needs of the community and would not require transport. However, Mohammad and Gikonyo<sup>[10]</sup> reported that local caregivers were more likely to experience stigma, discrimination, and social isolation due to the nature of their work. A better understanding of their duties and roles by community leaders would reduce the level of rejection by the communities they serve.

CHBC programs will need to have strong links with other organizations working in the vicinity, so as to

assist them with the nutritional, socioeconomic, legal, child support services, and their families. This can be achieved through an open channel of communication between organizations and the support of the larger and more prominent organizations within the communities. For a CHBC program to succeed in its goal, it requires the community's active stakeholder participation in the implementation and monitoring of programs to increase the impact and sustainability. This will involve People Living With HIV and AIDS (PLWHA) groups, local leaders, and community groups such as traditional leaders, ward councillor, and churches. This may result in the community's mobilization and advocacy efforts to organize resources for prevention, care, and support. However:

“Active involvement of the community does not automatically result in community mobilization for care, especially in communities with a high HIV prevalence and are therefore overwhelmed and do not easily take on other tasks. What will help community mobilization are effective linkages to external support services for orphan care, food support, income generating activities, loan and saving mechanisms.”<sup>[10]</sup>

### Organizational resources

The most common resource that was apparently the main challenge of the organizations was the lack of transport and rejections from members of the family. The transportation issue was divided into two categories: transport for the CHBC workers to the clients and transport for the clients to and from health facilities. To alleviate this challenge, some of the organizations requested “funds to pay for public transport of both the workers and the clients,” and this finding was similar to the finding of Mohammad and Gikonyo.<sup>[10]</sup> Alongside was the reported problem of bed-ridden clients who needed medical care, but were not near any public transport route.<sup>[10]</sup> Transport is a serious problem for the implementation of the activities, in general, but particularly for the transportation of the beneficiaries that are sick at home to the health units. Vehicles are extremely expensive, and there are many donors who do not pay for the acquisition of vehicles. To respond to this problem, some projects are using bicycles to which is attached a litter to facilitate the transport of patients to the hospital. It could be a cheaper way of addressing the problem of transport especially in rural areas. Other challenges were the lack of supplies to carry out CHBC activities such as HBC guidelines on CHBC, manuals on training personnel, and other educational material. Similar problems were also reported in other studies.<sup>[10]</sup>

## Main activities and services

The data on main activities and services were collected through questionnaire that was completed by the all CHBCs. From the responses, it is apparent that these main activities and services surrounded three objectives. One objective was to investigate if the CHBC course offered has equipped caregivers, the second was to evaluate if the implementation of CHBC services in Vhembe district was based on the national health guidelines, and the third was to identify problems and barriers hindering the delivery of CHBC services in Vhembe district, which is already outlined on organizational resources.

## Training/course offered

The training that caregivers received was very much sufficient to help them to provide excellent service under the circumstances. Refresher course is needed for new personnel, and management skills are a necessity for supervisor to be able to manage the organization properly.

## CONCLUSION

The results indicate that the majority of the members of CHBC in Vhembe District of Limpopo have enough knowledge on what they are doing; this is due to the educational levels that they have, which was also increased with the training that equipped them with more knowledge. The majority of respondents (about 40%) indicated that they do not have any barriers and discouragements in rendering CHBC in Vhembe District, although less than 1% indicated that management of Non-Government Organisation/Non-Profit Organisation (NGO/NPO) is not transparent.

There is a need for CHWs to be given more information on their operations on how they are carried out, and who carries these operations out. There should also be monitoring and evaluation programs for the main activities and services to determine if the client's needs are being met to improve the delivery of service. Effective CHBC cannot be provided without realistic financial support

for transportation, overheads, and logistics.<sup>[10]</sup> From the finding of this and previous research, it is clear that CHBC programs cannot be successful unless they receive active support and participation from the Government and Communities. Government should assume a greater role in CHBC provision to ensure patients and families have access to high quality of care, treatment, and support through the following: incorporate CHBC into district health plans; train and educate healthcare staff in the public health facilities on their necessary active participation in CHBC with an emphasis on the reduction of stigma and discrimination; care of the terminally ill at home should not be left to the families alone, they should be assisted by health professionals; a nationally recognized training program for CHW, which allows them to be certified in community home-based care, with the possibility of further training for placement within the healthcare system.

## REFERENCES

1. World Health Organization (WHO). Community home-based care in resource-limited settings. A framework for action: The cross cluster initiative on home-based long-term care. Geneva, Switzerland: WHO; 2002.
2. Department of Health. Department of Health National Guideline on Home-Base Care / Community-Based Care - December 2001. Pretoria; Department of Health; 2001.
3. Russell M, Schneider H. A rapid appraisal of community-based HIV/AIDS care and support programmes in South Africa. Johannesburg: Centre for Health Policy, University of Witwatersrand, 2000.
4. Uys L, Hensher M. The cost of home-based terminal care for people with AIDS in South Africa. *S Afr Med J* 2002;92:624-8.
5. Defilippi K. Integrated community-based home care: Striving towards balancing quality with coverage in South Africa. *Indian J Palliat Care* 2005;11:34-6.
6. Kaleeba N, Kalibala S, Kaseje M, Ssebhanja P, Anderson S, van Praag E, *et al.* Participatory evaluation of counselling, medical and social services of The AIDS Support Organization (TASO) in Uganda. *AIDS Care* 1997;9:13-26.
7. Kalibala S. Providing support to caregivers and self-care. *Sex Health Exch* 1999;1.
8. Sims R, Moss V. Terminal care for people with AIDS. Norwich, UK: Zarak Books; 1991.
9. Campbell C, Foulis C. Creating contexts for effective home-based care of people living with HIV/AIDS. *Curationis* 2004;27:5-14.
10. Mohammad N, Gikonyo J. Operational challenges community home based care (CHBC) for PLWHA in multi-country aids programs (MAP) in Africa. Washington DC: World Bank; 2005.

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